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Part B Insider (Multispecialty) Coding Alert

Documentation: Perfect Part B Documentation With These Pointers

Tip: Know the Medicare rules on medical record amendments.

One of the most important factors of concise medical documentation is that it allows you to track a beneficiary's progress over time; plus, it helps you collect payment for services performed. But not all Medicare providers keep their documentation in tiptop shape - and that can spell doom for your practice's bottom line.

That was the word from CGS Medicare's **Lisa Addison** during the Part B payer's webinar, "Principles of Documentation." Addison outlined several important tips that can allow you to perfect your practice's documentation and generate clean claims.

Understand Why Strong Documentation Is Essential

Maintaining pristine documentation should be the goal of every practice because it allows you to justify the reasons you performed certain services or ordered particular supplies, tests, or imaging services. This will, in turn, ensure that payers see the full picture of what the practice clinicians do during a particular visit, as well as why they did it.

"The purpose of having good documentation is to show that a claim has met all of the necessary coverage criteria for medical necessity," Addison said. This can help you determine if your claim will be covered by your payer. "Most policies contain coverage and documentation requirements that are unique to that specific policy … it's so important that you review the relevant local coverage determination (LCD) to ensure you have all the information necessary for the item or service you're providing to the beneficiary," she added.

For instance, an LCD might indicate that a particular procedure isn't payable unless the physician has documentation of a slit lamp test report on file. Always review the LCDs most applicable to your services and update your physicians when LCD requirements change. And remember: If you didn't document it, it didn't happen.

Save Documentation for 7 Years

Documentation doesn't expire after your claim is paid. In reality, you must be able to retain it for years.

"Be sure you have access to all medical records upon request. You're required to maintain all documentation and medical records for seven years," Addison advised. "If Medicare has paid a claim and conducts a post-pay audit and you cannot produce the supporting documentation upon request, Medicare will recoup the money paid on the claim," she continued.

"The documentation is there to validate the site of service; the medical necessity and appropriateness of the supplies, equipment, and services provided; and/or that items furnished have been accurately reported."

CMS Doesn't Dictate Record Format

In most cases, your practice is free to maintain documentation in the media format that works best for you, Addison said. Although some practices believe they must maintain paper copies of all claims, that's not necessarily the case.

The Centers for Medicare & Medicaid Services (CMS) doesn't have requirements dictating the media formats for medical

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records, but "the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities," CGS guidance indicates.

You Can Amend the Medical Record - If You Follow the Rules

Everyone makes mistakes, and if your provider makes one in the medical record, they can correct it, but you must follow your insurer's requirements.

Amendments and corrections to the medical record are possible with Medicare claims, Addison noted, but you must meet certain rules. "In all cases, regardless of whether the documentation is maintained or submitted in paper or electronic form, any medical records that contain amendments, corrections, or addenda must meet these criteria," she said:

- Clearly and permanently identify any amendment, correction, or delayed entry as such;
- Clearly indicate the date and author of any amendment, correction, or delayed entry; and
- Not delete, but instead clearly identify all original content.

When amending electronic medical records, you should distinctly identify any amendment, correction, or delayed entry - you must also provide a reliable way to clearly identify the original content, the modified content, and the date and authorship of each modification of the record. "Provide both the original record and any amendments that were made to the original note," Addison said. "Failure to provide a complete medical note or a record with changes inconsistent with the CMS manual instructions may result in a claim denial."

If you're correcting a paper record, "use a single-line strikethrough so the original content is still readable," she explained. "The author of the alteration must sign or initial and date the revision."

In addition, any amendment or delayed entry to paper records must also be clearly signed and dated upon entry into the record, she cautioned.

You Must Meet All Amendment Rules - Not Just One

Medical record amendments require you to meet all three bullet points above - not just one or two of them. Payers often see errors when people try to amend or correct their medical records. For instance, someone might change information, but forget to sign/initial and date it. In other situations, people try to write over the date, and reviewers can't read it at all. Instead, you should clearly cross it out, write the new date legibly, and then initial and date that.

For example, an error might involve a physician writing in after the fact, "History of juvenile cataracts," but the doctor only initials it, and never dates the amendment. "These are small errors, but they can have a big impact on your claim or the outcome," Addison said. "You don't want to find out that you have missing documentation in the middle of an audit," she warned.

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